posterior part of the urethra should be found. If the posterior end is not readily found, a suprapubic cystotomy should be performed and then by a retrograde catheterism the end found and the urethrotomy completed.

3. In case of a lesion of the posterior urethra he performs an external perineal urethrotomy with the aid of a staff. Cystotomy and retrograde catheterism are indicated in certain cases, as of traumatic origin, as in fracture of the pelvis.

In *résumé*, he says: 1. Hypogastric puncture is an excellent device; but it is expectant treatment to be used in emergency. It is without effect upon the lesion which is responsible for the retention.

2. Suprapubic cystotomy is a palliative and, at the same time, a curative measure. It is indicated in cases of infected prostatitis where there are false passages, and in cases where repeated catheterism has not re-established the urethra. It is the first step in many operations upon the posterior urethra. It is the second step in certain operations on the anterior urethra.

Iodides in the Thyroid Gland.—WEISS (*Münch. med. Woch.*, January 5, 1897) comments upon the richness in iodides of the glands of the inhabitants of Breslau, as shown by the researches conducted in the clinic of Prof. Ponfick. The amount of iodide was determined in the thyroid glands of adults who died from various causes, in persons suffering from goitre who died from an intercurrent disease, and in infants.

In fifty adults who died from sixty to seventy-seven years of age the desiccated thyroid weighed, on the average, 7 gr. 2, and contained 4 mgr. 0.04 of iodide. The average weight of the thyroid gland of the inhabitants of Silesia is, therefore, less than that of the inhabitants of Berlin (7 gr. 4), and of Freiburg (8 gr. 2), and greater than that of the inhabitants of Hamburg (4 gr. 6.) On the contrary, the average amount of iodide contained in the thyroid glands of the inhabitants of Breslau is greater than that of the inhabitants of Hamburg (3 mgr. 83) and of Freiburg (2 mgr. 5) and less than that of the inhabitants of Berlin (6 mgr. 6).

In the case of patients suffering from goitre the amount varied according to whether the patient had or had not been treated previously with the iodides. In those, to the number of nine, who had not been treated by the iodides, there were found traces, in two cases, and quantities varying from 6 to 11 mgr. In eleven cases treated by the iodides the amount found was from 12 to 18 mgr. In children under seven years the amount varied from traces to 0 mgr. 0.07 to 0 mgr. 0.78.

Congenital Fibro-papilloma of the Sole of the Foot.—DUIET (*La Méd. mod.*, November 4, 1896) reported the following interesting and rare case to the French Surgical Society: the patient, a boy, fifteen years of age, had a congenital tumor on the sole of his foot, which was painless, and of the thickness of four or five fingers; it occupied the entire sole of the foot and extended up on the sides and toes. It was traversed by deep furrows. The veins of the leg and thigh were exceedingly varicose, and were as large as one's thumb, and had the appearance of a cirsoid aneurism. The neoplasm made its appearance in the patient's third year, as small white elevations, hard, and the size of a pin's head in the centre of the foot.

Extirpation seemed impossible on account of the tenderness of the scar and the attending contractions. The author decided to remove it by abrasion. He employed a histological section-knife, after having removed the greater part of the tumor in small pieces with strong scissors. At the end of a few weeks fresh healthy granulations sprung up, and he succeeded in covering them by Thiersch's method of skin-grafting, and the patient is now able to walk, two years since the operation, without any pain or injury to the surface, and without recurrrence.

The Causation of Chloroform Syncope.—After a careful and comprehensive study, HILL (*British Medical Journal*, April 17, 1897) comes to the following conclusions:

1. Chloroform produces a primary failure of the circulating mechanism and a secondary failure of the respiratory centre. The respiratory centre fails to act not only because it is damaged by the drug, but because of the anæmia of the spinal bulb produced by the fall of arterial tension. This is proved by the fact that the action of the respiratory centre can be renewed by raising the arterial tension. The depth of anæsthesia depends, as does the paralysis of the respiratory centre, on the primary fall of the arterial tension.

2. Chloroform, more than any other known agent, rapidly abolishes the vascular mechanisms which compensate for the hydrostatic effect of gravity.

3. Chloroform abolishes these mechanisms by paralyzing the splanchnic vasomotor tone and by weakening the action of the respiratory pump. When these mechanisms are totally abolished the circulation is impossible if the subject be in the feet-down position.

4. Chloroform also produces paralytic dilatation of the heart. It acts directly like amyl nitrite on the musculature of the whole vascular system.

5. There are two forms of chloroform syncope: (*a*) during primary anæsthetization. The patient struggles, holds his breath, raises the intrathoracic pressure, congests his venous system, lowers his arterial tension, and finally takes deep inspirations and surcharges his lungs with chloroform. In the first stage the left heart becomes impoverished; in the second stage it is suddenly filled with blood. This is drawn from the lungs, and is full of chloroform. The chloroform passes into the coronary arteries, and the heart is thrown into paralytic dilatation. Respiration and the pulse either cease simultaneously or the pulse before respiration. (*b*) During prolonged anæsthetization this arises from gradually giving chloroform to too great an extent. The arterial pressure falls lower and lower, and, secondarily, the respiration ceases because of the anæmia of the spinal bulb. The heart is not in this case paralyzed by chloroform, because the drug is taken in gradually by the shallow respirations and distributed slowly by the feeble circulation.

6. Artificial respiration and the assumption of the horizontal position, if applied in time, will always resuscitate a patient from the second form of syncope.

7. Artificial respiration, established with the patient in the horizontal position, is also the treatment indicated in the first form of syncope; the heart should be rhythmically compressed by squeezing the thorax. If this does